IPRS

Integrated Payment and Reporting System

Instructions related to Transactions based on ASC X12 Implementation Guides, version 005010X222A1 Health Care Claim: Professional 837P

Companion Guide Version Number: 1.0

September 1, 2011

Preface

Companion Guides (CG) may contain two types of data, instructions for electronic communications with the publishing entity (Communications/Connectivity Instructions) and supplemental information for creating transactions for the publishing entity while ensuring compliance with the associated ASC X12 IG (Transaction Instructions). Either the Communications/Connectivity component or the Transaction Instruction component must be included in every CG. The components may be published as separate documents or as a single document.

The Communications/Connectivity component is included in the CG when the publishing entity wants to convey the information needed to commence and maintain communication exchange.

The Transaction Instruction component is included in the CG when the publishing entity wants to clarify the IG instructions for submission of specific electronic transactions. The Transaction Instruction component content is limited by ASCX12's copyrights and Fair Use statement.

Table of Contents

Transaction Instruction (TI)

1 TI Introduction

1.1 Background

1.1.1 Overview of HIPAA Legislation

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 carries provisions for administrative simplification. This requires the Secretary of the Department of Health and Human Services (HHS) to adopt standards to support the electronic exchange of administrative and financial health care transactions primarily between health care providers and plans. HIPAA directs the Secretary to adopt standards for transactions to enable health information to be exchanged electronically and to adopt specifications for implementing each standard HIPAA serves to:

- Create better access to health insurance
- Limit fraud and abuse
- Reduce administrative costs

1.1.2 Compliance according to HIPAA

The HIPAA regulations at 45 CFR 162.915 require that covered entities not enter into a trading partner agreement that would do any of the following:

- Change the definition, data condition, or use of a data element or segment in a standard.
- Add any data elements or segments to the maximum defined data set.
- Use any code or data elements that are marked “not used” in the standard’s implementation specifications or are not in the standard’s implementation specification(s).
- Change the meaning or intent of the standard’s implementation specification(s).

1.1.3 Compliance according to ASC X12

ASC X12 requirements include specific restrictions that prohibit trading partners from:

- Modifying any defining, explanatory, or clarifying content contained in the implementation guide.
- Modifying any requirement contained in the implementation guide.

1.2 Intended Use

The Transaction Instruction component of this companion guide must be used in conjunction with an associated ASC X12 Implementation Guide. The instructions in this companion guide are not intended to be stand-alone requirements document. This companion guide conforms to all the requirements of any associated ASC X12 Implementation Guides and is in conformance with ASC X12's Fair Use and Copyright statements.

1.3 Intended Audience

This companion guide is intended for the business and technical users, within or on behalf of trading partners, responsible for the testing and setup of electronic claims submissions to North Carolina MMIS+, which is used to report both Medicaid and IPRS claims. In addition, this information should be communicated to, and coordinated with, the provider's billing office in order to ensure that the required billing information is provided to its billing agent/submitter.

1.4 Purpose of Companion Guide

The Companion Guide is to be used with, and to supplement the requirements in the HIPAA ASC X12 Implementation Guides, without contradicting those requirements. Implementation Guides define the national data standards, electronic format, and values for each data element within an electronic transaction. The purpose of the Companion guide is to provide trading partners with a guide to communicate North Carolina IPRS specific information required to successfully exchange transactions.

The primary purpose of this document is to assist the trading partner with the submission of a valid 837 Professional claims transaction and is not intended to be a billing or policy guide.

1.5 Acknowledgements

A 999 Acknowledgement report will be sent to the trading partner's OUTBOX for retrieval. This report serves as the acknowledgement of the submission of a file. Typically, 999 Acknowledgement reports are available within moments of submission.

1.6 Trading Partner Agreement Setup

A Trading Partner Agreement (TPA) is a legal document that identifies the EDI partners, transaction sets, usage of data requirements, and file specifications. Providers or vendors, submitting claims to NC MMIS+ , are required to complete an updated Trading Partner Agreement-Appendix A. Follow the link to access the 5010 version of Appendix A at http://www.ncdhhs.gov/dma/hipaa/5010Appendix2.pdf. Complete and mail, with original signature to HP Enterprise Services – Attn. IPRS. Your completed TPA-Appendix A will then be forwarded to Medicaid for processing. You will be e-mailed a letter with instruction on how to proceed with 5010 transaction testing after your TPA-Appendix A has been processed.

1.7 Testing

NC MMIS+ requires testing, or third party certification, prior to approving a trading partner to submit claims in production. Once in production, NC MMIS+ reserves the right to require re-testing if it is determined the trading partner is receiving/generating an unacceptable volume of errors.

The following outlines the testing process:

- Prior to testing, a Testing Coordinator with the HPES ECS Department will discuss the expectations and testing process with the trading partner
- Trading partner will be assigned testing submitter information

- Tests may be submitted during regular business hours, Monday through Friday, 8 am to 5 pm, EST.
- The trading partner will be notified when test files can be sent to NC MMIS+. Typically, NC MMIS+ requires 5 compliant claims transactions containing 5-25 claims each.
- The claims submitted should be a general representation of the types of claims that are normally submitted
- Typical turnaround time for a test files is 48 hours, but is dependent on the volume of testing
- Once testing is complete, the ECS Testing Coordinator will notify the trading partner to review the test results and guide the trading partner into production
- When necessary, the ECS Testing Coordinator may monitor the first few production submissions to ensure compliance.

2 Included ASC X12 Implementation Guides

This table lists the X12N Implementation Guides for which specific transaction Instructions apply and which are included in Section 3 of this document.

Unique ID	Name
005010X222	Health Care Claim: Professional (837)
005010X222A1	Health Care Claim: Professional(837)

3 Instruction Tables

These tables contain one or more rows for each segment for which a supplemental instruction is needed.

Legend
SHADED rows represent “segments” in the X12N implementation guide.
NON-SHADED rows represent “data elements” in the X12N implementation guide.

005010X222 Health Care Claim: Professional

Loop ID	Reference	Name	Codes	Notes/Comments
Header	**ISA**	**Interchange Control Header**		**The ISA is a fixed-length record with fixed-length elements.** **NOTE: Deviating from the standard ISA element size will result in a rejected file.**
	ISA03	**Interchange Control Security Information Qualifier**	**00**	**For NC MMIS+, use “00” – No Security Information Present.**
	ISA05	**Interchange ID (Sender) Qualifier**	**ZZ**	**For NC MMIS+, use “ZZ” – Mutually Defined.**
	ISA06	**Interchange Sender ID**		**For NC MMIS+, use the 4 or 5 digit Submitter ID/Mailbox # issued by NC MMIS+**
	ISA07	**Interchange ID (Receiver) ID**	**ZZ**	**For NC MMIS+, use “ZZ” – Mutually Defined.**
	ISA08	**Interchange Receiver ID**	**NCXIX**	**For NC MMIS+, use “NCXIX” – North Carolina Title 19.**
Header	**GS**	**Functional Group Header**		

	GS02	**Application Sender's Code**		**For NC MMIS+, use the 4 or 5 digit Submitter ID/Mailbox # issued by NC MMIS+. This is the same value as provided in the ISA06.**
	GS03	**Application Receiver's Code**	**NCXIX**	**For NC MMIS+, use "NCXIX" – North Carolina Title XIX.**
Header	**ST**	**Transaction Set Header**		
	ST03	**Implementation Conversion Reference**	**005010X222A1**	**Refer to section 1.2 of Implementation Guide**
1000A	**NM1**	**Submitter Name**		
	NM108	**Identification Code Qualifier**	**46**	**For NC MMIS+, use "46" - Electronic Transmitter Identification Number (ETIN) established by a trading partner agreement**
	NM109	**Identification Code**		**For NC MMIS+, use the 4 or 5 digit Submitter ID/Mailbox # issued by NC MMIS+. This is the same value as provided in the ISA06.**
1000B	**NM1**	**Receiver Name**		
	NM103	**Receiver Name**	**NCXIX**	**For NC MMIS+, use "NCXIX" – North Carolina Title XIX.**
	NM109	**Receiver Primary Identifier**	**NCXIX**	**For NC MMIS+, use "NCXIX" – North Carolina Title XIX.**
2000A	**PRV**	**Billing Pay-To-Provider**		
	PRV01	**Provider Code**	**BI**	**For NC MMIS+, use "BI" to indicate billing provider**

	PRV02	**Reference Identification Qualifier**	**PXC**	**For NC MMIS+, use qualifier "PXC" – Health Care Provider Taxonomy Code.** **Note: not required for atypical providers.**
	PRV03	**Provider Taxonomy Code**		**Provider Taxonomy Codes, as maintained by the National Uniform Claim Committee, can be obtained from www.wpc-edi.com/hipaa.** **Submit the Provider Taxonomy that best fits provider type and specialty for the billing provider.**
2000B	**SBR09**	**Claim Filing Indicator Code**	**MC**	**For NC MMIS+, use "MC" - Medicaid**
2010BA	**NM1**	**Subscribers Name**		
	NM102	**Entity Type Qualifier**	**1**	**For NC MMIS+, use "1" to indicate the subscriber is a person.**
	NM108	**Identification Code Qualifier**	**MI**	**NC MMIS+, use "MI" -Member Identification Number Qualifier**
	NM109	**Subscriber Primary Identifier**		**For NC MMIS+/IPRS, enter the member's 10-digit identification number ending in an alpha character or the 11 digit IPRS client ID (facility code + client record number) may be submitted and cross-referenced for processing**
2010BB	**NM**	**Payer Name**		

	NM109	**Identification Code**	**DNC00 - Claims** **DNC00 – Medicaid Replacement/Void** **NCDMH – IPRS Replacement/Void**	**For NC MMIS+, use "DNC00" for claims.** **For NC Medicaid, use "DNC00" for replacements and voids.** **For NC IPRS, use "NCDMH" for replacements and voids.** **Note: When CLM05-3='7' or '8', the financial payer must be designated in this field. When CLM05-3='1', this field should contain "DNC00".**
	REF	**Billing Provider Secondary Identification**		
	REF01	**Reference Identification Qualifier**	**G2**	**For NC MMIS+, use "G2" to report Atypical provider data.**
	REF02	**Reference Identification**		**For NC MMIS+, use the NC MMIS+ issued provider number.**
2300	**CLM**	**Claim Information**		
	CLM05-3	**Claim Frequency Code**	**1 – Original – Admit thru Discharge Claim** **7 – Replacement – Adjustment Claim** **8 – Void – Recoupment Claim**	**For NC MMIS+, use one of the following claim frequency codes: '1', '7' or '8' to indicate the type of claim being submitted.**
	DTP	**Initial Treatment Date**		

	DTP01	**Date/Time Qualifier**	**454**	**For NC Medicaid, this segment is used to report the first date of treatment/ first date seen.**
	PWK	**Claim Supplemental Information**		
	PWK01	**Attachment Report Type Code**	**OZ**	**For NC Medicaid submit "OZ" – Support Data for Claim – only to be used in combination with PWK02 to indicate Medicare does not cover the service submitted Follow rules of implementation guide for other claim paperwork**
	PWK02	**Attachment Transmission Code**	**AA**	**For NC Medicaid, submit "AA" – Available on Request at Provider Site – only to be used to indicate Medicare does not cover the service. NC Medicaid billing instructions for Medicare Overrides, or Medicare voucher indicating the service was not covered by Medicare must be kept on file at the provider's site. Follow rules of implementation guide for other claim paperwork** **Note: For NC IPRS, this combination of values is equivalent to an F2 Stamp**
	HI01	**Health Care Code Information**		

	HI01-1	**Code List Qualifier Code**	**BK**	**For NC IPRS, use "BK" – Principal Diagnosis ICD-9 Codes (primary)** **Note: Reason for treatment is the primary diagnosis in IPRS.**
2310A	**NM**	**REFERRING PROVIDER NAME**		**For NC IPRS, use to report the responsible Referring LME, whose budget will be debited to pay for the claim** **Note: Claims processing will always occur against the Provider data submitted at the header level**
	NM101	**Entity Identifier Code**	**DN**	**For NC IPRS, use "DN" for the responsible LME Referring Provider**
	REF	**Referring Provider Secondary Identification**		**For NC IPRS, this segment is required by IPRS if the Referring Provider is atypical**
	REF01	**Reference Qualifier Identifier**	**G2**	**For NC IPRS, use "G2" to report the Referring LME's Provider Number**
	REF02	**Reference Identification**		**For NC IPRS, enter the responsible LME's non-alpha suffix base provider number**

2310B	**NM**	**Rendering Provider Name**		**For NC MMIS+, this segment is required when the Rendering provider is different from the Billing Provider** **Note: Claims processing will always occur against the Provider data submitted at the header level**
	NM103	**Name Last or Organization Name**		**Note for NC IPRS: If this is a hard coded-value, recommend coding 'Area Program/Contract Provider'**
	REF	**Rendering Provider Secondary Identification**		**For NC IPRS, this segment is required when Rendering Provider is different from Billing Provider and Rendering is atypical**
	REF01	**Reference Identification Qualifier**	**G2**	**For NC IPRS, use "G2" to report the Attending Provider**
	REF02	**Reference Identification**		**For NC IPRS, use IPRS Attending Provider Number. This can be any enrolled IPRS Billing or Attending Provider Number**
2310C	**NM**	**Service Facility Location**		**For NC IPRS, use the Provider Number in which the service was rendered**
	REF	**Service Facility Location Secondary Identification**		**For NC IPRS, this segment is Required by IPRS if Service Facility Location Provider is atypical**
	REF01	**Reference Identification Qualifier**	**G2**	**For NC IPRS, use "G2" for the Location Number**
	REF02	**Reference Identification**		**For NC IPRS, enter the agency number as it is enrolled in IPRS**

2320	**AMT**	**Coordination of Benefits Payer Paid Amount**		
	AMT01	**Amount Qualifier Code**	**D**	**NC MMIS+ only use "D" – Payer Amount qualifier code in this AMT segment, no other qualifiers used in claims processing.**
2400	**SV101 – 1**	**Product/Service ID Qualifier**	**HC**	**For NC MMIS+ use "HC" – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes**

4 TI Additional Information

4.1 Business Scenarios

4.1.1 Unknown Values

A trading partner may not have all the data necessary to plug every required element on the transaction. In these cases, the following values are suggested as placeholders:

"UNKNOWN" – for alphanumeric fields, as defined by the HIPAA Implementation Guide.

"99991231" – for dates fields, as defined by the HIPAA Implementation Guide.

"111111111" – for Social Security Number fields, as defined by the HIPAA Implementation Guide.

The submission of these values does not guarantee payment. All claims are subject to the NC Medicaid edits and audits.

4.2 Scheduled Maintenance

Systems maintenance is performed on an as needed basis and announce in advance.

4.3 Frequently Asked Questions

No FAQ at this time.

4.4 Other Resources

- Washington Publishing Company (WPC) at www.wpc-edi.com
- ASC X12 at www.x12.org
- National Uniform Billing Committee www.nubc.org
- North Carolina Division of Mental Health (DMH) at http://www.ncdhhs.gov/mhddsas/
- NC IPRS Electronic Commerce Services (ECS) 1-800-688-6696. Menu option 4 then menu option 2

5 Change Summary

Date	Change	Responsible Party
09/01/2011	Original Document	5010 Implementation Team